Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

The Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To assess the extent to which financial screening and distinct part rules limit access to nursing facilities for Medicare and Medicaid beneficiaries.

BACKGROUND

The Health Care Financing Administration (HCFA) requested that the Office of Inspector General (OIG) conduct a study about nursing home certification and admissions practices that may limit access to care for Medicaid and Medicare beneficiaries. These practices are distinct part certification and financial screening.

In recent years, HCFA and the Office of Civil Rights (OCR) have been alerted by nursing home advocacy groups and beneficiaries that nursing homes may be using financial screening and distinct part rules to limit access for Medicare and Medicaid applicants. Facilities can request financial information from beneficiaries as part of their admissions process and can designate a distinct part by certifying a specific number of their beds for Medicare and/or Medicaid. There is some concern, however, that facilities are using these practices to deny access to Medicare and Medicaid beneficiaries.

To address these concerns, we interviewed State Long Term Care Ombudsmen, State Medicaid officials, a sample of hospital discharge planners, and a sample of nursing home administrators. We also contacted several oversight agencies about complaints they have received related to these issues. Additionally, we analyzed data from the National Ombudsman Reporting System (NORS) and the Online Survey Certification and Reporting System (OSCAR) to assess complaints and the nursing home bed supply.

FINDINGS

Distinct Part Certification

Overall, distinct part rules do not appear to limit access for Medicaid or Medicare beneficiaries. Twenty-nine States allow nursing homes to certify a portion of their beds for Medicaid. The remaining 22 States have a "one bed, all beds" policy that requires nursing homes that participate in Medicaid to certify all of their beds for Medicaid. Irrespective of these rules, about 97 percent of all beds that are certified nationwide are for Medicaid. In addition, Medicaid officials report no significant problems with distinct part. Ombudsmen generally concur, although some express concerns.

Regarding Medicare, all but one State allow nursing homes to certify a portion of their beds for Medicare. However, access to Medicare beds does not appear to be a problem according to respondents and previous OIG studies.

Financial Screening

Nursing facilities commonly request financial information as part of the admissions process. Ombudsmen, Medicaid officials, and nursing home administrators report that facilities commonly ask for financial information, often about a person's assets, income, and insurance.

When financial screening occurs, it primarily affects access for Medicaid beneficiaries. While no Medicaid officials and only eight ombudsmen report that Medicaid beneficiaries are "very often" denied access to a nursing home because of financial screening, one-third of discharge planners say that nursing homes refuse patients "very often" for financial reasons. Many discharge planners note that Medicaid patients are most likely to be affected by these practices.

Complaints

Oversight agencies receive relatively few complaints about financial screening or distinct part practices. The Office of Civil Rights (OCR) and the OIG Hotline could document virtually no complaints about financial screening or distinct part practices. Ombudsmen from 24 States estimate receiving an average total of 339 complaints related to financial screening per year. Over two-thirds of these complaints come from 7 States. Regarding distinct part practices, ombudsmen in 20 States estimate receiving an average total of 334 complaints per year. Similarly, three-quarters of these complaints are from 6 States. The total number of complaints represents less than one percent of all complaints reported by ombudsmen in a year.

CONCLUSION

Distinct part rules do not appear to limit access for Medicaid or Medicare beneficiaries. Financial screening may cause access problems for some Medicaid beneficiaries, but these problems do not appear to be widespread. At this time, any potential effects of distinct part rules and financial screening are being tempered by a bed supply that generally exceeds demand and by State initiatives that promote access. The dynamics of the nursing home bed supply, however, could change in the future.

The Department can respond to these findings with a number of options.

- It can do nothing new at this time and continue to monitor access and changes in nursing home occupancy rates, as well as the factors that affect nursing home bed supply and demand;

- It can strengthen its oversight efforts by alerting survey and certification and ombudsman staff to potential abuses and by using public service announcements to alert consumers to common financial screening practices;

- It can issue new regulations or legislation that eliminates Medicare distinct part and/or prohibits financial screening; or

- It can study the effects on access of the practices adopted by 23 States to promote access to nursing facilities.

AGENCY COMMENTS

We received comments on the draft report from the Health Care Financing Administration (HCFA), the Administration on Aging, and the Assistant Secretary for Planning and Evaluation (ASPE). The HCFA agreed with our recommendation to strengthen oversight and listed a number of steps they were taking to implement that recommendation. Additionally, at ASPE's request we have forwarded a memorandum to HCFA containing a State-specific discussion of access. The ASPE also asked for a discussion of the variance in responses listed in Table 2. We believe the variance is due to perspective. While the State officials take a policy or oversight view of the problem, the discharge planners' view is that of a caseworker focusing on the process of placing beneficiaries. We elaborate on this on page 16 of the report with our follow-up interviews with discharge planners.

Technical comments have also been included in the report. The full text of the agencies' comments are contained in Appendix B.

TABLE OF CONTENTS

INTRODUCTION

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In recent years, HCFA and the Office of Civil Rights (OCR) have been alerted by nursing home advocacy groups and beneficiaries that nursing homes may be using financial screening and distinct part rules to limit access for Medicare and Medicaid applicants. These groups have also been concerned that such limitations may have a disparate impact on minorities because they are less likely to have financial resources.

Medicare Program

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as Medicare. Medicare provides insurance to people who are 65 years and older; people who are disabled; and people with permanent kidney failure.

Medicare consists of two primary parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. Medicare Part A provides coverage of inpatient hospital care, skilled nursing facility care, home health services, and hospice care. Medicare Part B pays for the cost of physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies with a coinsurance.

Skilled nursing facility (SNF) care is covered by Part A only if the care is generally within 30 days of a hospitalization of 3 or more days, and is certified as medically necessary. The number of SNF days provided under Medicare is limited to 100 days per benefit period, with a co-payment required for days 21 through 100. Medicare Part A does not cover nursing facility care at all if the patient does not require skilled nursing or skilled rehabilitation services.

Medicaid Program

Medicaid was established under Title XIX of the Social Security Act and is the principle payer of nursing home care. The program is administered by the States, but is funded jointly by the States and the Federal Government. A State must present a State Medicaid plan to HCFA for approval in order to obtain Federal funding.

Medicaid is designed to provide assistance for medical care to low-income people. Medicaid pays for nursing facility care for recipients who meet a State-determined poverty level, provided the nursing facility is certified for the program. The amount paid is determined by each State and covers room, board, and nursing care. Although it is voluntary, the majority of facilities participate in the Medicaid program.

Distinct Part Certification

Facilities use distinct part certification to define the extent of their participation in the Medicaid or Medicare program. To do this, they can certify a specific number of their beds for either or both of these programs. Distinct part rules for Medicare and Medicaid differ somewhat and are described below.

Medicare

Under Medicare, a facility can certify a part or all of its facility for Medicare. The part has to be a physically identifiable unit of an institution such as a separate wing or a floor of the facility.

The practice of distinct part has been used primarily for cost reporting purposes. Until recently, SNFs were reimbursed based on a retrospective, reasonable cost basis. Under this system, some nursing homes perceived a financial incentive to limit their program participation by establishing a distinct part. Specifically, facilities could track their costs for their distinct part and their non-distinct part separately. Their Medicare distinct part costs, which were likely to be higher than their non-distinct part costs because of the care required for skilled services, was a factor in determining a facility's reimbursement.

The Balanced Budget Act of 1997 (BBA97) changed SNF reimbursement to a prospective payment system (PPS). Under this system, SNFs are paid through "per diem, prospective, case-mix adjusted" payments. Each resident is categorized into one of 44 "resource utilization groups" and payment is based on the level of care that each resident requires. The system is currently being phased in over a 3 year transition period. Under this new system, distinct part is no longer a factor in determining the reimbursement rates for SNFs.

Prior to this year, SNFs were allowed to change the size of their distinct part as needed. As of January 1999, a SNF can change the size of its distinct part only once during its cost reporting year.

Medicaid

Distinct part rules for Medicaid vary by State. Some States require facilities that choose to participate in the Medicaid program to certify all of their beds for Medicaid. Other States mirror the Federal rule for Medicare in that individual facilities can determine the size of their distinct part.

The use of Medicaid distinct part has been challenged. In April 1990, the District Court for the Middle District of Tennessee ruled, in Linton v. Tennessee Commissioner of Health and Environment, that Tennessee's practice of allowing a nursing facility to certify some, but not all, of its beds for Medicaid participation violated both the Medicaid statute and Title VI of the Civil Rights Act of 1964. In July 1990, the court approved a plan that requires certification of all available licensed nursing home beds in facilities that participate in Medicaid. The plan also requires participating nursing facilities to admit residents on a first-come, first-serve basis and prohibits involuntary transfer or discharge based upon source of payment.

Financial Screening

Facilities may request financial information from applicants as part of their admissions process. As part of the Omnibus Reconciliation Act of 1987 (OBRA '87), Congress passed the comprehensive Nursing Home Reform Act (PL 100-203) which provides some protections to Medicaid beneficiaries with respect to nursing home admission practices. The statutes and regulations, however, do not explicitly address whether nursing facilities may financially screen applicants and base admissions on their ability to pay. The law does not prohibit facilities from rejecting potential admissions, except to the extent that the practice violates the Civil Rights Act or Rehabilitation Act requirements, which prohibits discrimination against individuals with disabilities.

The discussion about financial screening has centered around several requirements. These include provisions of the Social Security Act titled *Equal Access to Quality Care -- (1819(c)(4) and 1919 (c)(4)(A))* . They state that "a facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment" (42 CFR 483.12 (b)(c)(1)). Additional requirements state:

> (d) *Admissions policy* (1)The facility must- (i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and (ii) the facility must not require oral or written assurance that residents or potential residents are not

eligible for, or will not apply for, Medicare or Medicaid benefits...(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.

General Concerns

In recent years, some beneficiaries and advocacy groups have complained that facilities are using distinct part and financial screening to limit the number of Medicaid and Medicare beneficiaries they admit.

Specifically, facilities allegedly use distinct part to inform applicants that they do not have a Medicaid or Medicare bed available and that the person can only be admitted if he or she pays privately. (Facilities prefer private pay residents largely because they can charge these patients higher rates than the amount they are reimbursed for patients under Medicare or Medicaid.) Reportedly, facilities may also use distinct part to limit access to residents who initially pay privately for care and later become eligible for Medicaid. In this situation, facilities may tell these beneficiaries that there is no Medicaid bed available and that they must move.

Similarly, facilities allegedly use financial screening to deny access to Medicaid patients or persons who will be eligible for Medicaid in the near future. Reportedly, some facilities require applicants to submit information about their finances so that they can determine whether or not and for how long the person will be able to pay privately before they become eligible for Medicaid.

Nursing Home Industry Concerns

The American Health Care Association and the American Association of Homes and Services for the Aging, the primary associations for nursing homes, have strongly objected to any limitations on financial screening and on their ability to have distinct parts. Their arguments hinge on the need for financial solvency and their desire to avoid additional regulation.

Additionally, nursing homes have raised concerns about the new PPS reimbursement system for Medicare beneficiaries. They believe that the system is causing considerable stress on the industry. They claim that the prospective payment system is reducing payments to SNFs and may cause some SNFs to go out of business.

Nursing Home Surveyors

Nursing Home surveyors carry out the State survey and certification process for determining nursing home compliance with Federal standards. The HCFA contracts with States to perform routine facility surveys for Medicare and dually-certified nursing homes. The State is also responsible for surveying its Medicaid certified nursing homes. Surveyors perform unannounced visits to all facilities no later than every 15 months of the previous survey. During their visits, they review compliance with residents' rights and audit residents' assessments and plans of care for a sample of residents to determine accuracy and adequacy. When a facility fails to meet a specific requirement, they cite the facility for noncompliance.

Long Term Care Ombudsman Program

The State Long Term Care Ombudsman Program is a federally mandated program established in 1978 in the Older Americans Act. The program began in response to concerns about poor quality of care in nursing homes. The program operates in all 50 States, the District of Columbia, Puerto Rico, and in hundreds of local communities. The program has multiple functions, many of which are closely tied to ensuring residents' rights and quality care. These functions include:

- Identifying, investigating, and resolving complaints made on behalf of long term care residents;
- protecting the legal rights of residents;
- advocating for systemic change;
- providing information and consultation to residents and their families, and;
- publicizing issues of importance to residents.

In 1996, all programs began to collect and report data under the National Ombudsman Reporting System (NORS). This system includes information about complaints made on behalf of residents about residents' rights, resident care, quality of life, administration, and other complaints not against the facility.

METHODOLOGY

This inspection is based on information gathered from several different sources. As described below, we conducted interviews with a broad range of stakeholders who have experience with beneficiary access to nursing homes. We also analyzed data from the Online Survey Certification and Reporting System (OSCAR) and data about complaints from several different sources.

Interviews

First, we interviewed the State Long Term Care Ombudsman from each State (except Alaska who was not available at the time) and the District of Columbia to identify any complaints they have received about financial screening and distinct part practices. We also asked about the extent to which access to nursing home care is a problem in their State.

Second, we contacted State Medicaid officials in each State and the District of Columbia to obtain information about their distinct part requirements and policies that promote nursing home access. We also discussed the extent to which financial screening and distinct part may limit access for Medicaid beneficiaries in their State.

Third, we conducted interviews with 180 randomly selected hospital discharge planners in eight States. We asked them about their experiences with placing Medicare and Medicaid patients in nursing homes and about any reasons why access to nursing home care may be a problem in their area. Results from these interviews are also reported in a related study entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities* OEI-02-99-00400.

Fourth, we interviewed 64 nursing home administrators in eight States. We asked them about access to nursing homes and about how they make decisions concerning which types of patients to admit. Results from these interviews are reported in another study entitled, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Nursing Home Administrators' Perspectives* OEI-02-99-00401.

OSCAR Data

The Online Survey Certification and Reporting System (OSCAR) is the system HCFA uses in its survey of Medicare and Medicaid providers to monitor State agency and provider performance. We analyzed OSCAR data from the most recent survey and the Provider of Services (POS) File to determine the number of nursing home beds and nursing home occupancy rates in each State. We also analyzed data about two deficiencies concerning admissions and equal quality of care that nursing home surveyors may cite in their annual review of each nursing facility. These two deficiencies, identified as deficiency tags 207 and 208, reflect the requirements in the Nursing Home Reform Act discussed earlier.

Complaint Data

We identified the key agencies that beneficiaries and others may contact about problems related to access to nursing home care. We asked these agencies about any complaints related to financial screening and distinct part rules. In addition, we analyzed the

National Ombudsman Reporting System (NORS) for FY 1997. (Note that FY 1998 data were not available.) We also asked each ombudsman about any complaints specifically related to financial screening and distinct part that they received in the past three years. These data were annualized to estimate the average number of complaints received in a year.

Sample Selection

We selected a two-stage stratified cluster sample of hospital discharge planners and nursing home administrators in eight States. The first stage of sampling was a stratified sample of eight States as shown below.

Strata 1	The four States with the most SNF beds (CA, NY, IL, TX)
Strata 2	Two of the four States currently using a Medicaid demonstration prospective payment system (MS, ME)
Strata 3	Two States randomly selected from the remaining 40 contiguous States (VA, CT)

At the second stage, we selected a simple random sample of eight nursing homes that had greater than 60 beds within each of these States. We also selected a simple random sample of 25 hospitals within each of these States. We achieved a 100 percent response rate for nursing home administrators and a 90 percent response rate for discharge planners. Data for both samples were weighted and projected to the universe. Note that the estimates based on these samples are associated with large confidence intervals and should be interpreted with caution. Appendix A provides the confidence intervals for the key questions.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

F I N D I N G S

DISTINCT PART CERTIFICATION

Most States allow distinct part certification in nursing homes

According to Medicaid officials, 29 States allow nursing homes to certify a portion of their beds for Medicaid. Three of these States actually specify what percentage of a nursing home's beds that must be certified for Medicaid. The remaining 22 States do not allow Medicaid distinct part certification. These States have a "one bed, all beds" policy that requires nursing homes that participate in Medicaid to certify all of their beds for Medicaid.

Regarding Medicare, all but one State allow nursing homes to certify a portion of their beds for Medicare. In the remaining State, all beds must be certified for both Medicare and Medicaid.

Overall, distinct part rules do not appear to limit access for Medicaid or Medicare beneficiaries

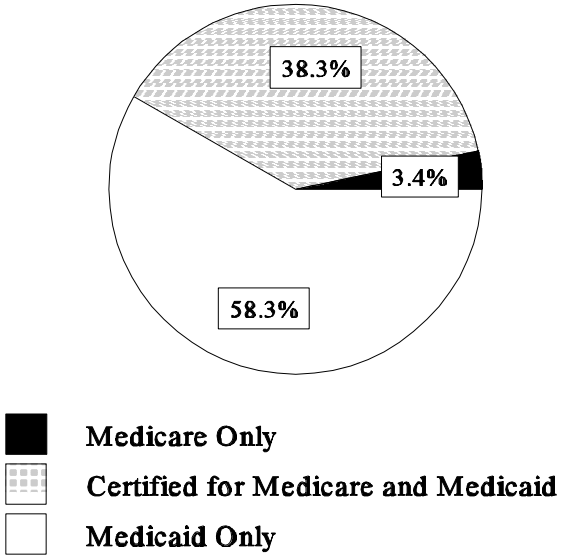
Irrespective of the rules about Medicaid distinct part, only about 875 facilities or 5 percent of 17,317 facilities nationwide appear to have a Medicaid distinct part. Further, as shown in Figure 1, about 97 percent of all beds that are certified nationwide are for Medicaid. At the same time, about 68 percent of nursing home residents are Medicaid beneficiaries. It is important to note, however, that even if a bed is certified for Medicaid, the facility does not have to fill it with a Medicaid beneficiary.

Regarding Medicare, according to 1998 OSCAR data, 8971 facilities or about half of all facilities nationwide have a Medicare distinct part and about 42 percent of all certified beds are for Medicare. Note that only about 9 percent of nursing home residents are Medicare beneficiaries.

As shown, many beds (38 percent) are actually certified for both Medicare and Medicaid. The number of these beds has also increased from 1996 to 1998 by 7 percent. Medicaid officials from 39 States confirm that it is "very common" for nursing homes in their State to certify their beds for both programs and several note that facilities are increasingly certifying their beds in this manner.

Figure 1

Percent of Certified Beds by Category



Source: Provider of Services File, 1998

In addition, no Medicaid officials report that distinct part limits Medicaid beneficiaries' access to nursing homes in their State to a large extent. (See Table 1.) Some explain that due to their State's "one-bed all-beds" policy, distinct part does not affect access. Others note that occupancy rates are low and therefore nursing homes do not refuse applicants in order to keep their beds filled. Also, Medicaid officials in States that allow distinct part for Medicaid are less likely to report that overall access is a problem for Medicaid beneficiaries than those in States that do not allow distinct part.

Ombudsmen generally concur with Medicaid officials but some express concerns. Ombudsmen in seven States believe that distinct part limits access for Medicaid beneficiaries to a large extent. Another 18 ombudsmen say that distinct part limits access to some extent. A few mention instances where a family was told that a nursing home did not have a Medicaid certified bed available when that may not have been the case.

Table 1
Effect of Distinct Part on Access

To what extent does distinct part limit Medicaid beneficiaries' access to nursing homes?

	Large	Somewhat	Not at all	Don't know
Medicaid Officials	0	5	43	3
Ombudsmen	7	18	20	5

Source: OEI Surveys, 1999

Ombudsmen are less likely to report that distinct part practices are a problem for Medicare beneficiaries. Specifically, only two ombudsmen report that distinct part limits access for Medicare beneficiaries to a large extent. Another 21 ombudsmen say that it limits access to some extent. Some ombudsmen report that nursing homes want Medicare beneficiaries and others note that they do not hear complaints about Medicare beneficiaries being denied access because a Medicare bed is not available.

Finally, when asked their opinions, most Medicaid officials (35) believe that requiring nursing facilities to certify all of their beds for both Medicare and Medicaid would not have an effect on access for Medicaid beneficiaries in their State. Similarly, the majority of nursing home administrators report that it would not affect the number of Medicare or Medicaid patients that they would admit. In contrast, ombudsmen generally believe that this requirement would increase access for Medicare and for Medicaid beneficiaries.

FINANCIAL SCREENING

Nursing facilities commonly request financial information as part of the admissions process

State ombudsmen and Medicaid officials report that nursing homes routinely ask for financial information as part of the admissions process. Specifically, 41 ombudsmen and 40 Medicaid officials note that nursing homes do this "very often" or "somewhat often." Most nursing home administrators (75 percent) confirm that they ask for financial information when a person applies to their facility, most often about a person's assets, income, and/or insurance. Some note their facility requires an advance deposit for applicants who plan to pay privately.

When financial screening occurs, it primarily affects access for Medicaid beneficiaries

No Medicaid officials and only eight ombudsmen report that Medicaid beneficiaries are denied access to a nursing home "very often" because of financial screening. (See Table 2.) Eleven ombudsmen, however, report Medicaid beneficiaries are denied access "somewhat often" because of financial screening. They commonly explain that nursing facilities want to maximize their reimbursement and clearly prefer private pay and Medicare applicants. Regarding Medicare beneficiaries, only one ombudsman believes that these beneficiaries are denied access "very often" because of financial screening.

Table 2
Effect of Financial Screening on Access

How often are Medicaid beneficiaries denied access to a nursing home because of financial screening?

Respondent	Very Often	Somewhat Often	Not Often	Never	Don't Know
Medicaid Officials*	0	2	30	12	7
Ombudsmen*	8	11	19	10	2

How often do nursing homes refuse patients because of financial reasons?

Discharge Planners	33%	37%	23%	7%	0%

Source: OEI Surveys, 1999

* Responses from Medicaid Officials and Ombudsmen are in terms of their counts, not percentages.

Ombudsmen in 15 States further note that it is at least somewhat common for nursing homes in their State to require a person to pay privately for a specified period of time in order to be admitted. According to their experience, a person may be required to pay for a month or more which is inconsistent with the current law.

In contrast, discharge planners believe that financial screening is a common problem. One-third say that nursing homes refuse patients "very often" because of financial reasons. Another 37 percent say that this happens "somewhat often." Some note that patients with complex medical conditions, patients without any insurance, and Medicaid patients are most likely to be denied access because of financial screening.

To understand these issues further, we contacted the discharge planners (15) who say that nursing homes refuse patients "very often" because of financial reasons and that it is "very difficult" to place Medicaid patients in nursing homes. Seven respondents report that they can place all of their patients in a nursing home. Another 3 say they cannot place up to 10 percent, whereas 4 cannot place between 25 and 88 percent of their Medicaid patients. Most note that these patients remain in the hospital for long periods of time. In some cases, they may eventually be placed in a nursing home or in other types of care. They also report that the patient's medical condition or low reimbursement under Medicaid is the primary reason they have difficulty placing these patients.

Nursing home administrators generally believe that financial screening is not a large problem. The majority of nursing home administrators (85 percent) assert that they do not look at payment source to decide the proportion of Medicare, Medicaid, and private pay patients to admit. Rather, many say they take whoever applies or make decisions based on bed availability or whether they can meet a patient's needs. Others explain that they try to admit as many private pay patients as possible.

When asked their opinions about financial screening rules, most ombudsmen and many Medicaid officials believe there should be at least some limitations on financial screening. A typical comment is that financial screening should not be used to "shop" for residents. Some ombudsmen note that it is important for nursing homes to be able to screen residents so they can remain financially solvent and be able to provide quality care to all.

In contrast, about two-thirds of nursing home administrators believe there should not be any limits placed on financial screening. They commonly say they need to ask for financial information so they can know how their facility will be paid. Some specifically point out that they are operating a business and need this information to protect themselves financially. Others say that they use the information to help plan a resident's stay or to assist them in applying for Medicaid when they become eligible.

COMPLAINTS

Oversight agencies receive relatively few complaints about financial screening or distinct part practices

Beneficiaries and others may contact certain agencies including the Office of Civil Rights (OCR), the OIG Hotline, and/or the Ombudsman Program about problems related to access to nursing home care. Additionally, nursing home surveyors may cite facilities for admissions practices that do not assure equal access to care and for certain financial screening practices. The available data are presented below.

The Office of Civil Rights. Staff at OCR did not find any complaints in which financial screening or distinct part was an issue in FY 98 or FY 99. They note that three complaints remain open from the early 1990's which allege that certain Michigan area nursing homes use distinct part rules and financial screening to limit access for Medicaid beneficiaries and minorities.

The Office of Inspector General Hotline. Staff identified only one complaint related to payment source that was received by the OIG Hotline between May 1995 and September 1999. This complaint alleges that a nursing home asked Medicaid residents to leave so that it could admit private pay residents.

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Nursing home surveyors. Nursing home surveyors rarely cite nursing homes for problems related to equal access to care or financial screening. According to OSCAR data for the most recent survey, surveyors gave a total of 59 citations related to these issues. These citations represent less than one percent of all citations given in that time period.

Ombudsmen. According to 1997 NORS data, ombudsmen report a total of 1,262 complaints in categories that may include issues related to distinct part and financial screening practices. Together, these complaints represent less than one percent of all complaints reported by ombudsmen in that year.

When asked to look at their data more specifically, 17 ombudsmen report they have not received any complaints about financial screening and 18 ombudsmen report that they have not received any complaints about distinct part practices. Ombudsmen from 24 States estimate receiving an average total of 339 complaints related to financial screening per year. The majority (71 percent) of these complaints come from 7 States. Regarding distinct part practices, ombudsmen in 20 States estimate receiving an average total of 334 complaints per year. Similarly, about 76 percent of these complaints are from 6 States. Note that not all ombudsmen were able to obtain these data.

Ombudsmen explain that these complaints are primarily about nursing homes denying access to Medicaid beneficiaries or those who would become Medicaid eligible in the near future. Some involve facilities requesting extensive financial information from patients or their family members, or asking residents to pay a certain amount prior to admission. Several ombudsmen also mention complaints about beds not being available, possibly because of distinct part practices.

In addition, 23 State ombudsmen estimate an average total of 734 complaints per year about issues related to access to care. These complaints primarily involve residents being transferred from one bed to another when they become eligible for Medicaid. Others are about residents being discharged either to a hospital or for a psychological evaluation so that the nursing home could fill the bed with a Medicare or private pay resident.

At the same time, many ombudsmen believe that problems caused by financial screening and distinct part are larger than what is actually reported. Some note that people may not complain or be aware that they are being denied access because of financial screening or distinct part rules. They also mention that many people may not know to notify the Ombudsmen program if they have this type of problem.

OVERALL ACCESS

The effects of distinct part rules and financial screening must be viewed within the broader context of overall access to nursing home care. Overall access is primarily affected by the supply of and demand for nursing home beds which can be measured in terms of occupancy rates.

Occupancy rates are low and most respondents report that overall access to nursing home care is not a major problem

According to OSCAR data, occupancy rates are generally low. Specifically, the average occupancy rate for all certified nursing facilities nationwide is 82 percent. State occupancy rates range from 68 percent in Arkansas to 95 percent in New York. Many ombudsmen and Medicaid officials confirm that nursing homes are experiencing low occupancy rates. Some explain that this is due to more people obtaining care in alternative settings such as assisted living facilities or at home. Several also note that some nursing homes are eager to accept anyone, or prefer some guarantor of payment to having a vacant bed.

Further, respondents report that overall access to nursing homes is not a major problem for Medicaid beneficiaries. Specifically, no Medicaid officials say that access to nursing home care for Medicaid beneficiaries is a large problem. (See Table 3.) Nursing home administrators generally agree. Only 6 percent report that access to nursing home care for Medicaid patients is a large problem in their area. Medicaid officials and nursing home administrators commonly explain that enough beds are available to meet demand. Others note that access is somewhat of a problem for persons with complex care needs or with certain medical conditions or in some areas of their State.

In contrast, ombudsmen from 11 States report that access for Medicaid beneficiaries is a large problem in their State. They point out that facilities prefer private pay or Medicare patients. Similarly, about one-third of discharge planners report that it is “very difficult” to place Medicaid patients in nursing homes, mainly because Medicaid reimbursement is low.

Table 3
Overall Access for Medicaid Beneficiaries

To what extent is access to nursing home care a problem for Medicaid beneficiaries?

	A large problem	Somewhat of a problem	Not at all a problem	Don't know
Medicaid Officials*	0	19	30	2
Ombudsmen*	11	24	15	0

How difficult it is to place Medicaid patients in nursing homes?

	Very difficult	Somewhat difficult	Not at all difficult
Discharge Planners	35%	42%	23%

Source: OEI Surveys, 1999

* Responses from Medicaid Officials and Ombudsmen are in terms of their counts, not percentages.

Regarding Medicare, fewer respondents report that access to nursing home care is a problem. Only five ombudsmen report that access for Medicare beneficiaries is a large problem in their State. (See Table 4.) Many observe that occupancy rates are low or that there are enough beds. Some note, however, that the nursing home prospective payment system has created some difficulties or that access problems exist for patients with complex medical needs or in some areas in their State.

Discharge planners and nursing home administrators generally concur. Only one percent of discharge planners report that it is "very difficult" to place short-term Medicare patients. They point out that nursing homes generally want Medicare patients because they have short stays or because their reimbursement for these patients is higher than it is under Medicaid. Similarly, about 6 percent of nursing home administrators report that access to nursing home care for Medicare patients is a large problem in their area.

Table 4
Overall access for Medicare Beneficiaries

To what extent is access to nursing home care a problem for Medicare beneficiaries?

	A large problem	Somewhat of a problem	Not at all a problem	Don't Know
Ombudsmen*	5	26	18	1

How difficult it is to place short-term Medicare patients in nursing homes?

	Very difficult	Somewhat difficult	Not at all difficult	Don't Know
Discharge Planners	1%	32%	66%	1%

Source: OEI Surveys, 1999

* Responses from Ombudsmen are in terms of their counts, not percentages.

We also found that many States (23) have specific policies to promote nursing home access. According to Medicaid officials, 13 States have occupancy incentives in which the State reimburses nursing homes at a higher Medicaid rate when their occupancy reaches a certain level, such as 95 percent. Five States mandate that all nursing homes use a single waiting list, or a first-come, first-served policy to assure access for Medicaid recipients. Two States have a rate equalization policy that prohibits a facility from charging private-pay patients a higher rate than it is paid under Medicaid.

Some States have other policies such as bed-hold policies that specify certain conditions in which a nursing home cannot deny readmission to a beneficiary who leaves a facility for a short amount of time. A few States also have a resident bill of rights that prohibits discrimination based on payment source. The majority of Medicaid officials in States that have policies believe that the policies are "somewhat" or "very" effective at assuring access.

CONCLUSION

Distinct part rules do not appear to limit access for Medicaid or Medicare beneficiaries. Financial screening may cause access problems for some Medicaid beneficiaries, but these problems do not appear to be widespread. At this time, any potential effects of distinct part rules and financial screening are being tempered by a bed supply that generally exceeds demand and by State initiatives that promote access. The dynamics of the nursing home bed supply, however, could change in the future.

The Department can respond to these findings with a number of options.

- It can do nothing new at this time and continue to monitor access and changes in nursing home occupancy rates, as well as the factors that affect nursing home bed supply and demand;
- It can strengthen its oversight efforts by alerting survey and certification and ombudsman staff to potential abuses and by using public service announcements to alert consumers to the current law and common financial screening practices;
- It can issue new regulations or legislation that eliminates Medicare distinct part and/or prohibits financial screening; or
- It can study the effects on access of the practices adopted by 23 States to promote access to nursing facilities.

AGENCY COMMENTS

We received comments on the draft report from the Health Care Financing Administration (HCFA), the Administration on Aging, and the Assistant Secretary for Planning and Evaluation (ASPE). The HCFA agreed with our recommendation to strengthen oversight and listed a number of steps they were taking to implement that recommendation. Additionally, at ASPE's request we have forwarded a memorandum to HCFA containing a State-specific discussion of access. The ASPE also asked for a discussion of the variance in responses listed in Table 2. We believe the variance is due to perspective. While the State officials take a policy or oversight view of the problem, the discharge planners' view is that of a caseworker focusing on the process of placing beneficiaries. We elaborate on this on page 16 of the report with our follow-up interviews with discharge planners.

Technical comments have also been included in the report. The full text of the agencies' comments are contained in Appendix B.

APPENDIX A

Confidence Intervals for Discharge Planners and Nursing Home Administrators

We calculated confidence intervals for key findings for discharge planners and nursing home administrators. The point estimate and 95% confidence interval are given for each of the following:

DISCHARGE PLANNERS	POINT ESTIMATE	CONFIDENCE INTERVAL
In your opinion, how often do nursing homes refuse patients because of financial reasons?		
Very often	33%	± 3.7
Somewhat often	37%	± 16.0
Not often	23%	± 18.8
Never	7%	± 2.2
Currently, how difficult is it to place Medicaid patients? Would you say:		
Very difficult	35%	± 15.8
Somewhat difficult	42%	± 8.4
Not at all difficult	23%	± 8.5

DISCHARGE PLANNERS (continued)	POINT ESTIMATE	CONFIDENCE INTERVAL
Currently, how difficult is it to place short-term Medicare patients into nursing homes? Would you say:		
Very difficult	1%	± 1.3
Somewhat difficult	32%	± 6.6
Not at all difficult	66%	± 4.3

NURSING HOME ADMINISTRATORS	POINT ESTIMATE	CONFIDENCE INTERVAL
In your opinion, to what extent is access to nursing home care a problem for Medicaid patients in your area? Would you say it is:		
A large problem	6%	± 8.7
Somewhat of a problem	33%	± 16.9
Not at all a problem	62%	± 25.2
In your opinion, to what extent is access to nursing home care a problem for Medicare patients in your area? Would you say it is:		
A large problem	6%	± 8.8
Somewhat of a problem	26%	± 34.5
Not at all a problem	68%	± 26.1

APPENDIX B

Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: MAY 26 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "The Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities," (OEI-02-99-00340)

Thank you for the opportunity to review and comment on this report. As a result of concerns that nursing home advocacy groups and beneficiaries raised to the Health Care Financing Administration (HCFA) and the Office of Civil Rights (OCR), HCFA requested that the OIG conduct this study to assess the extent to which financial screening and distinct part rules may limit access to nursing facilities for Medicare and Medicaid beneficiaries. The information gathered by the OIG will help us make sound policy decisions about how best to protect the interests of those Americans who need nursing home care.

Nursing home residents deserve and expect access to safe, quality care. In 1998, the Clinton Administration began an aggressive initiative to improve enforcement of federal and state nursing home standards and to promote quality care for nursing home residents. HCFA now requires states to crack down on homes that repeatedly violate health and safety standards and has strengthened the inspection process to increase its focus on preventing bedsores, malnutrition, and abuse. In addition, HCFA has created Nursing Home Compare, a searchable database available at www.medicare.gov, to give consumers access to comparative information about nursing homes, including annual inspection results and the health status of residents. HCFA is taking these actions to make sure that residents get the quality care and safe environment that they deserve.

America's nursing home residents should not live in fear that they will be evicted solely because they rely on Medicaid to pay for their care. To this end, President Clinton signed legislation in March 1999, to protect nursing home residents who depend on Medicaid. The legislation provides that nursing homes that choose to stop taking new Medicaid patients would be prohibited from transferring or evicting the Medicaid patients they already have. Further, the legislation provides that nursing homes that choose not to accept Medicaid patients will have to notify new residents able to pay their own way at first that the residents may have to move once they run out of money and need to rely on Medicaid.

Effective October 1, Medicare will increase payment rates to skilled nursing facilities for those residents who have the most costly medical needs and will increase overall payments by an estimated 5.8 percent above the published rates for fiscal year 2000. The proposal creates new,

higher payment categories for residents with multiple, serious health problems that require intensive care and treatment. The changes, based on HCFA's extensive research of real-world experiences, will ensure that Medicare pays nursing homes fairly and appropriately for caring for those beneficiaries with complex medical needs.

We agree with and believe the best approach is your second option to strengthen oversight efforts by alerting survey and certification and ombudsman staff to potential abuses, and by using public service announcements to alert consumers to the current law and common financial screening practices. The report concludes that distinct part rules do not appear to limit Medicare and Medicaid beneficiary access to nursing facilities. The report also finds that, while financial screening may cause access problems for some Medicaid beneficiaries, the problems are not widespread. These conclusions do not support the need for new regulations. However we believe that strengthening oversight is warranted in light of the finding that some Medicaid beneficiaries may be experiencing access problems. Strengthening oversight will help ensure that Medicare and Medicaid beneficiaries have continued access to nursing facilities.

Under the option to strengthen oversight efforts, HCFA will direct states to refer complaints to the OCR where it appears discrimination was a factor in denying admission to a distinct part of a nursing home. At the same time, HFCA would also direct the state survey agency to keep the ombudsman apprised of such complaints. Where there appears to be a violation of Medicare and Medicaid participation requirements, states would be expected to investigate and take appropriate action. In addition, HCFA will alert consumers to common financial screening practices by incorporating this messaging into a media outreach strategy to provide information to all beneficiaries in need of long-term care. Through public service announcements and other information channels, we will provide consumers with information on how to report problems in gaining admission to nursing homes due to improper financial screening. Consumers will learn that they are entitled to "Equal Access Quality Care," regardless of source of payment.

Our technical comments on the audit report are attached. We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised.

Attachment

Technical Comments

Page 5--In the first sentence of the "Background," after the words "nursing home," we suggest that you insert "certification and." It would then read, ". . . conduct a study about nursing home certification and admission practices . . . ."

Page 7, last full paragraph--The provision "identified as Equal Access to Quality Care" is accurately identified with a regulatory citation; however, this would be more appropriately referenced to the statutory provision at 1819(c)(4) and 1919(c)(4)(A) which are expressly titled "Equal Access to Quality Care."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The Assistant Secretary for Planning and Evaluation
Washington, D.C. 20201

MAY 15 2000

TO: June Gibbs Brown
Inspector General

FROM: Margaret A. Hamburg, M.D.
Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Report Entitled, "The Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities," OEI-02-99-00340 - **Comments**

Thank you for the opportunity to review the report examining the effects of financial screening and distinct part policies on access to nursing facilities. During earlier discussions with OIG staff, we had requested that they consider identifying the States that were reported by various informants as having policies on financial screening and/or distinct part that created access problems. The request was made so that the (1) Department and others would be informed of which States were reported to have access problems, and (2) readers would be able to triangulate the informants' responses to identified whether certain States were consistently reported to have access problems because of various State policies.

Request for Information to the Department

This report does not identify the States for which nursing facility access problems were attributed to distinct part and financial screening policies. We understand that this information is not included because it would be possible to identify the persons who provided information, given the limited number of informants in each State. We are sympathetic to this problem. We request that the OIG provide the Department:

- a list of the States that were reported to have access problems because of financial screening and/or distinct part policies; and
- a summary of the nursing home admission policy information obtained from all States.

Recommended Changes to the Report

1. We understand the OIG collectively analyzed responses regarding distinct part and financial screening policies and could find no State that was consistently identified by the various informants as having access problems. We recommend the report be modified to include a discussion of this finding.

2. With respect to access problems arising from financial screening policies, the OIG found (pp.19-20):

- no Medicaid officials reported access problems due to financial screening;
- ombudsmen in 12 States reported that Medicaid beneficiaries are either denied access "somewhat often" or "very often"; and
- that almost 70 percent of discharge planners reported that nursing homes either "very often" or "somewhat often" refuse to admit patients.

We were trouble by the variation in these responses. We recommend the OIG discuss and attempt to explain the range of responses.

3. On a technical note, we recommend the report identify the OSCAR data tags that were examined to assess whether deficiencies were cited concerning admissions and equal quality of care.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

RECEIVED
2000 MAY -4 AM 10: 33
OFFICE OF INSPECTOR GENERAL

APR 26 2000

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Aging

SUBJECT: OIG Draft Report: "The Effect of Financial Screening and Distinct Part Rules on Access to Nursing Facilities," OEI-02-99-00340

Thank you for the opportunity to review the above-referenced report, which provides much-needed information on an important nursing home issue.

We have only two minor suggestions for improving it:

1) On page 9, first paragraph under the ombudsman program heading, Puerto Rico should be added to the jurisdictions in which the ombudsman program operates.

2) Since the intent of the OBRA '87 language on financial screening has been widely discussed and can be interpreted in various ways, it would be helpful to the reader if the statutory language were included on page 7, or as a note in the report.

This report will be widely read in the state and local ombudsman network. We appreciate the opportunity to comment.

IG
EAIG
PDIG
DIG-AS
DIG-EI ✓
DIG-OI
DIG-MP
OCIG
ExecSec ✓
Date Sent 5-4

Jeanette C. Takamura